

Power, status and marginalisation: Rural social workers and evidence-based practice in multi-disciplinary teams.

ABSTRACT

This paper examines how evidence-based practice (EBP) is impacting on the professional status of social workers working in multi-disciplinary health teams in rural Victoria. Questionnaires and interviews were used to investigate the use and perceived appropriateness of EBP, and the implications for the professional status of social workers. The results indicated that social workers have the lowest levels of knowledge and application of EBP. The qualitative data revealed a fundamental incompatibility between social work practice approaches and the science of EBP. The key themes identified were: how undergraduate and professional training shapes practitioner perspectives around EBP; divergent knowledge of EBP, and how this influences team perceptions around the validity of social work practice; the ways EBP validates and reinforces existing power hierarchies, frequently to the exclusion of social work practitioners; the power of EBP as a mechanism for practice legitimisation; the marginalisation of social work as a discipline resisting the science of EBP; and the way the rural context shapes the impact of EBP in the practice setting.

Keywords

Evidence-based practice, rural & remote practice, marginalisation

Introduction

The profession of social work is grappling with the paradigm of evidence-based practice. Educators, policy-makers and researchers are divided about the challenges and opportunities afforded by the use of research findings to inform practice decisions. On the one hand, the Campbell Collaboration is developing both the infrastructure and the methodologies to prepare,

and make accessible, systematic reviews of the effectiveness of interventions in social work, education and criminal justice (Schuerman et al., 2002). In addition, curricula are being reviewed to equip social work graduates with the skills to identify, critically appraise, and apply scientific evidence to their practice (Howard, McMillen, Pollio, 2003). On the other hand, evidence-based approaches are claimed to be based upon a narrow, deterministic, rationalistic view of human behaviour that draws social workers into a managerialist agenda aimed at regulating and controlling practitioners (Webb, 2001).

Evidence-based practice involves the "conscientious, explicit and judicious use" of the best available evidence to make decisions about the best care of clients (Sackett, and Rosenberg, 1996, p.2). It uses "individual expertise to integrate the best external evidence, based on research findings, with information about a client's characterizations and circumstances, and the client's preferences and actions" (Gibbs and Gambrill, 2002, p. 453). Imperatives for the use of evidence-based practice are that it aims to reduce ineffective treatments, minimise the risk of harm, and maximise the benefits of the selected interventions (National Health & Medical Research Council (NHMRC), 1999).

Some of the major arguments against EBP in social work have been identified and rebutted by Gibbs and Gambrill (2002). Some social workers assert that it ignores clinical expertise, is formulaic in prescribing treatments, results in therapeutic nihilism if there is no solid research base for particular presenting issues, and promotes authority-based practice. It has also been criticised for its strong medical orientation, and the marginalisation of evidence other than that collected through randomised control trials (Dunston and Sim, 2000).

The merits and demerits of EBP - both to inform practice decisions and as a strategy to strengthen the professional standing of social work - is being keenly debated by the social work profession in Australia. There is, however, a dearth of empirical research into the current levels

of uptake of EBP and the experiences of social work practitioners in a range of settings who are encountering this new paradigm.

This paper is part of a larger doctoral study investigating the applicability and adoption of EBP by multidisciplinary healthcare teams in rural areas. The specific objectives of this paper are, against the backdrop of a rural context, to:

1. Measure levels of knowledge, attitudes towards, and use of evidence-based practice by social workers;
2. Describe perceptions by social workers of the appropriateness of evidence-based approaches to their practice; and
3. Examine the implications of evidence-based practice for professional status of social work.

Description of the Study

The findings outlined in this paper result from case studies of three health services located in a large regional city, a rural town and a remote town in Victoria. Study participants comprised rural practitioners based in acute and sub-acute hospitals who provide services in both hospital and community settings. All participants worked in multi-disciplinary healthcare teams under the clinical leadership of a medical practitioner. Both quantitative and qualitative data were collected using structured questionnaire and interview techniques. A forty-seven item questionnaire, distributed to 331 health practitioners across the three study sites, was used to assess practitioner knowledge, skill, attitudes and use of evidence in practice. The overall return rate for questionnaires was 62% (n=207) with a return rate of 53% (n=9) from the social work cohort employed across the study sites.

Semi-structured interviews were conducted across the three health sites over an eight month data collection period from May to December 2002. Individual interviews were undertaken

with 50 multi-disciplinary team members representing 11 different discipline areas. Six social work practitioners were involved in the individual interviews; the highest number of representatives from any single discipline, with the exception of nursing. Group interviews were also conducted with 5 multidisciplinary/ management teams and 10 additional interviews were undertaken with management level staff. Social work practitioners were participants in all multi-disciplinary team interviews. Interview questions focused on clarifying practitioners' knowledge of EBP, the extent to which inter- and intra-disciplinary practice bases affect adoption and/or acceptance of the paradigm, and the impact of organisational context on the uptake of rural multidisciplinary EBP. The interview transcripts were read several times and independently analysed by the two researchers to establish inter-rater reliability. Data were thematically analysed using the processes of open coding, axial coding and selective coding described by Strauss and Corbin (1990).

Results and Discussion

While data analysis identified a number of emergent themes applicable to the focus of the larger doctoral project, the specific areas to be reported on in this paper are:

- The divergent knowledge about, usage of and attitudes towards EBP by rural practitioners;
- The appropriateness of EBP as a paradigm for rural social work practice exploring the competing notions of science and humanism; and,
- EBP and professional status within the rural multi-disciplinary team exploring:
 - Practice legitimisation
 - Power hierarchies
 - Discipline marginalisation.

Knowledge, Usage and Attitudinal Diversity

Practitioner knowledge of EBP was assessed through both questionnaires and interviews.

Analysis of questionnaires showed that medicine, psychology and physiotherapy consistently rated highest in their knowledge of EBP, while the disciplines of social work, nursing, podiatry and prosthetics/orthotics rated lowest. The only discipline found to have rated 'low', across all sites, was social work, with eight out of the nine participants having a 'low' rating on knowledge of the evidence base available to inform their practice areas. Triangulation of interview and questionnaire data showed a consistent trend for higher levels of knowledge amongst the more scientific disciplines. This is in line with previous study findings identifying greater knowledge of EBP among scientific disciplines (Cochrane, 1999; Dawes, M., Davies, P., Gray, A., Mant, J., Seers, K. and Snowball, R., 1999; Ferlie, E., Woog, M. and Fitzgerald, L., 1999) and lesser knowledge in the social work field (Hemmings, 2000; Sheldon 1998; Webb, 2001).

The majority of social work practitioners identified that they were '*not sure clearly what the definition of (EBP) is*' while analysis of interview feedback, across all sites, highlighted a lack of a common language to even define what is meant by the term 'evidence-based practice'.

In essence, there was a general consensus, across all sites, that social work, as a discipline, was struggling to understand EBP.

Differences in knowledge levels were also found to vary across the three sites, and were influenced by the capacity of the social workers to access information both about the paradigm itself and about current research of relevance to their field of practice. While all social work participants acknowledged difficulties in accessing resources and professional development on EBP, linked to the lack of a uniform, professional position on the paradigm and the shortage of social work research evidence, those from the rural city and the remote town identified additional dimensions to the problem. As rurality increased, access to resources and professional development decreased. This was caused by a poor information technology

infrastructure and the vast geographical distances and major staff shortages that act as inhibitors to accessing staff training opportunities. These factors significantly influenced knowledge about EBP and highlighted an intra-disciplinary dimension to the inter-disciplinary differences already impacting on adoption of EBP in the multi-disciplinary context.

Not surprisingly, knowledge about EBP was strongly related to its frequency of use to inform practice. Across the three sites, questionnaire data confirmed that, while nineteen out of twenty-four medical practitioners, six out of seven psychologists and fourteen out of seventeen physiotherapists use evidence frequently (at least once a month), only four out of nine social workers were frequent users of evidence. Usage was found to diminish as rurality increased. Four out of six social workers from the regional city accessed evidence frequently, none of the social work practitioners from the rural town accessed evidence more often than once every six months, and practitioners from the remote town reported that they did not use any formal evidence to inform practice. All social workers involved in the study identified that they worked with complex multi-dimensional issues that are inherently at odds with the uni-dimensional focus of EBP. However, this incompatibility was magnified in the remote practice environment. In the remote town, workers are generalists operating across very diverse fields of practice in *'isolated areas where, if someone has a need, we find a way to address that need'*. The scope of service provision and expectations placed on a sole practitioner operating over a large geographical area limits their capacity to allocate time to the pursuit of formal evidence frameworks. As one interviewee explained *'you don't have time to sit there and read 20 articles. Time is very, very tight and this influences what evidence and research we access'*.

Given these locality and discipline-based differentials, clarification was sought on social workers' attitudes to EBP. The questionnaire results showed that four of the nine social workers viewed EBP negatively. The five remaining practitioners viewed EBP more positively and considered the use of EBP to make a clinical decision, by particular professions such as medicine and physiotherapy, as likely to benefit patient outcomes. For these professions, social

workers thought that EBP would be '*be a highly valued and highly desirable work practice*'.

They did not, however, include themselves as a profession that should use EBP.

Open-ended questionnaire responses yielded additional data revealing that knowledge and perceptions of EBP are often linked to whether practitioners consider evidence to be relevant to their particular practice model and work context. Comments such as, '*Many of the skills/competencies in social work cannot be tested through EBP*', signalled that discipline-based differences needed to be qualified to fully understand the full scope of variations that the statistical data measures simply as discrepancies in knowledge and attitude. The interview data reinforced that social work practitioners are primarily influenced by contextual, disciplinary and individual client issues and operate in a practice model largely at odds with the science of EBP.

Science and humanism

All disciplines, with the exception of social work, linked their conversance with EBP to either the fact that scientific evidence was a central aspect of the medical model advanced in training, or to the increased role played by EBP in the practice models of their discipline areas. This finding held true across all three sites. In direct contrast to this, all social work participants identified EBP as missing both from their initial formal training and from ongoing professional development. All social work participants rated their discipline as non-scientific and assessed that this had been significant in shaping their perceptions of the relevance of EBP to their practice. A major strand of social work practice derives from the humanist perspective, which Horner & Kindred (1997, pg 16) define as, 'a theory which assumes that human beings are trying to make sense of their world and that human behaviour can only be understood from the viewpoint of the client(s)'. The primacy of this perspective to practice was reinforced by participants' assessments that EBP is incompatible with the social work philosophy and practice models. It was unanimously identified that social work does not have science as '*the premise of the profession*'. Rather social work has been built, as a profession, '*very much around the clinical experience of people*'.

Participants, across all discipline areas, acknowledged that the variability in how practitioners construct their view of EBP is inextricably linked to their professional training and socialization, as well as by the nature of their work. Consequently, within a multi-disciplinary health team, the social worker is operating from a philosophy that is fundamentally at odds with the science of the medical model that informs the practice of the other health disciplines. The essence of this difference is captured in the following quote in which the incompatibility between the scientific/positivist perspective of the medical model and the humanism of social work is articulated:

We're dealing with human issues, with what's going on for the person; with feelings and emotions that aren't prescriptive ... It requires an understanding of the way people operate, it's a way of working, it's a belief system ... in the medical world, the assumption is 'doctors know best' ... In social work it's not for us to be prescribing what is right or what is going to fix the situation - you can't have a scientific response to that. And I think that's the fundamental difference.

While this difference was consistently identified by social workers across the three study sites, the nature of social work practice was assessed as being particularly isolating for practitioners operating in remote service locations. Social work practitioners working in the larger service centres, where more than one social worker is employed, have access to a level of peer support that is not available to the remote service practitioner. For the sole practitioner, working in a rural multi-disciplinary team with other disciplines who operate under a different practice model, the rift between science and humanism can be extremely isolating, as captured in the following quote:

It's professional isolation because, as much as you might work in a multi-disciplinary team, there is no one else in the team who understands the way you've been trained and your code of ethics and the way workers think... of course I'm going to look at a situation differently, to someone who has trained under the medical model.

Social work study participants identified that they faced a science/ practice wisdom dichotomy where, although '*practice wisdom drives our practice*', they increasingly feel they are required to justify their practice by reference to scientific evidence. This requirement contrasts with the training of the profession where '*by and large the nature of social work has been to gather a whole range of different perspectives and to try and meld those into a body of knowledge to work from*'.

Social work participants, across the three sites, argued that it is incorrect to assess that their practice is uninformed by evidence or that evidence is irrelevant to social work practice.

Practitioners simply indicated that their evidence-bases take alternative forms to the scientific data that characterizes the evidence-based movement. Evidence for social work practice takes the form of '*theories on human behaviour*', '*clinical wisdom*' and '*networking with like professionals and university schools of social work around developments in the field*'. There was a clear acknowledgement however, that in the scientifically-based health sector, these claims are unlikely to '*satisfy people in terms of saying "that's our evidence base"*'.

Social workers, without exception, identified that the lack of a structured hierarchy of evidence was problematic for them in the health service setting. This lack of evidence was adversely affecting the perceptions of other health professions about the validity of social work practice.

Practice legitimisation

Practice legitimisation, within the context of this study, refers to the legitimacy attributed to practice approaches, based on the extent to which treatment(s) can be shown to be supported by evidence and/or proven to have achieved measurable outcomes for clients. Interview feedback, from four out of the six social work participants, identified that while they, as a discipline, are satisfied with the research evidence and knowledge that underpins their practice, the underlying message, at the organisational level, is that '*we shouldn't feel comfortable to say that our*

clinical experience is sufficient to drive our practice. That that's not good enough'. All social work interviewees identified that it is very difficult, in the health service setting, to argue that 'the uniqueness of the situation is what we're about.'

The link between science and practice legitimacy was identified as being particularly notable in environments in which there were both social workers and psychologists involved in service delivery. In those instances, three out of four social workers identified that *'the psychologist's input is viewed as more valid (more scientific) even though we could be saying the same thing.'* Similarly, a practitioner working in a remote setting reported that, when their opinion is in conflict with an assessment by individuals from scientific disciplines, *'the lack of respect for my view appears to be quite a conflict and a waste of time'.*

Social work practitioners consistently acknowledged that they needed to develop mechanisms to allow for the validity of social work evidence to be acknowledged as *'social work is certainly not the top of the pops in terms of prestige and recognition'.*

While social workers did not see the road to legitimacy as lying with science, it was conceded, particularly at the regional city and rural town sites where there is a strong organisational commitment to EBP, that practitioners needed to review practice and seek to develop mechanisms to enhance validity. Traditional strategies of *'building networks'*, *'creating stronger links with universities'* and *'getting involved in site-based research studies'* were identified as the basis for building a structured evidence-based research framework. Adopting a formal process for advancing practice legitimacy was seen as being outside social work's traditional practice base. Four out of six of the social work practitioners interviewed felt that the profession was being forced to *'attempt to contrive a sort of a knowledge or practice base for us as a discipline which is to be considered equal to others'.*

Power hierarchies

The institutional health setting is typically characterised by medical dominance (French and Raven, 1959; Gair & Hartery, 2001; Willis, 1990), a situation in which medicine is allocated both position power (referring to the ability to influence because of position) and expert power (referring to the possession of special expertise that is highly valued). Other health disciplines are generally only attributed expert power (Cott, 1998; Lipman 2000). These power differentials impact on decision making in the multidisciplinary team. The dominance of medicine is further cemented by the practice legitimacy allocated by the centrality of science to medical practice, and the fact that all teams involved in the study operated under the clinical leadership of a doctor.

Results of this study clearly confirmed the dominant role played by medicine, and also revealed the structured power hierarchies operating in rural multi-disciplinary teams. Two specific types of informal power hierarchy were identified. The first was closely aligned to science. In this hierarchy, the medical practitioner was at the apex, and those with weaker links to science were at progressively lower levels of the hierarchy. In this structure, the adoption of EBP was identified, by the majority of study participants, as a central mechanism for staking claims to power and authority within the team. The second type of hierarchy was also headed up by the medical practitioner with nursing and then allied health at the lower levels. This structure was not so closely linked to EBP but rather reflected more remote practice environments in which the workforce comprises, in the main, nurse practitioners. Despite weaker links to EBP in this second type of power hierarchy, EBP was still considered a source of power. In both types of power hierarchy, social workers identified that *'social work is down the bottom of the pecking order in many, many ways. There's sort of a hierarchy and social work will be last'*. In the remote site, the social worker was so subordinate that the position was *'not even included in the formal organisational structure'*.

Discipline marginalisation

Interviews with management staff across the three sites clarified that they placed no expectation on social workers to use EBP. However, team members from other disciplines noted the failure of social work to have a scientific research basis to inform practice decisions. For example, one nurse commented *'they come from a non medical background and they fit into teams but often operate differently ...it's pretty airy fairy'* and a physiotherapist asserted that *'some of them just don't have any real evidence base... they seem not to'*.

It is important to note that social work was the only discipline, across the three study sites, about which this concern was raised. It was noted as a shortfall and, reinforced social workers' perception that *'EBP is seen as the only way to validate your work'*.

Within the evidence-based health sector, and because of organisational and government policy imperatives, social workers were disadvantaged. The lack of scientific evidence to inform practice decisions was seen, by the majority of social workers, as marginalising the discipline. Social work participants identified that *'professionally we are being devalued because we're unable to compete in that context and it needs to be recognised that our value is not seen as being equal,... It's almost as cut and dry as that and it is linked to the fact that there isn't an evidence base for social work'*. For the isolated sole practitioner, operating without peer support, the level of marginalisation was magnified to the point that the practitioner saw *'my clients as my greatest support'* and believed him/herself to be so marginalised within the multi-disciplinary team that *'I'm not seen as an expert in anything'*.

Discussion and Conclusion

This is one of the first Australian studies to investigate the consequences of the EBP movement for social workers in rural, multi-disciplinary, health care settings. While this study is based on a small, non-generalisable sample of nine social workers, the interview material and the responses of these workers provide a very strong indication of the issues. The results show that the institutionalisation of EBP within the health sector and into the professional training of a

range of health disciplines is impacting on social workers in a number of ways. The incompatibility of the paradigm to the humanism of social work practice is reinforcing existing power hierarchies in medical settings. In this context, where the capacity to support practice with evidence is now paramount, the lack of systematic evidence available to social workers, contributes to further marginalisation and subordination of the profession. This study has also demonstrated how EBP is difficult to apply and is largely inappropriate for isolated social workers in remote areas who lack training in EBP, do not have access to adequate information technology, and whose work is generalist rather than specialist. While the findings cannot be generalised to the non-institutional, non-acute, metropolitan settings, they nonetheless provide some critical insights into an area in which there is a current paucity of research knowledge.

The question arises whether social work should, or is compelled to, develop an evidence-based methodology if it is to gain status and recognition in relation to other disciplines. McDonald (2003) argues against the reliance on EBP to reposition and legitimise social work. She contends that an EBP framework is inappropriate because social science knowledge will always be incomplete, and social work draws upon divergent and contested knowledge bases. Further, she argues that EBP attends to immediate presenting problems and largely ignores structural issues such as power and disadvantage. These arguments are echoed by the practitioners in this study, but must be tempered by the reality of marginalisation and subordination of social work found in these three workplaces.

The social work profession in Australia, as elsewhere, faces some difficult choices about evidence-based practice. Should it embrace EBP and develop new practice approaches that formally and systematically apply evidence to decision-making? Or is social work fundamentally incompatible with the objectives, tenets, philosophy and methodology of EBP? Recent developments clearly indicate that matters of policy, education, information dissemination and coordination are starting to be addressed. For example, the Australian Association of Social Workers National Executive has lately agreed to the establishment of the

Australian Centre for the Establishment of Evidence-Based Practice in Social Work. The Association's Evidence-Based Practice Working Party is leading a number of capacity-building initiatives. It is important that good research underpins and supports the profession's strategic decisions about evidence-based practice in social work in Australia.

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